FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0020255

Facility Name: Piatt County Nursing Home

Address: 1111 N. State St (Number) Monticello (City) 61856 (Zip Code)

County: Piatt

Telephone Number: (217) 762-6305 **Fax #** (217) 762-6325

IDPA ID Number: 37-6001816001

Date of Initial License for Current Owners: 12/01/73

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Kelly Glennon **Telephone Number:** (217) 762-6305

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/99 to 11/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Karla Bradley

(Title) Executive Director

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/99 Ending: 11/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	100	Skilled (SNF)	100	36,600	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,600	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	186	242		428	8
9	SNF/PED					9
10	ICF	18,351	17,142		35,493	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,537	17,384		35,921	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.14%

D. How many bed-hold days during this year were paid by Public Aid?
117 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Senior Citizen Meals, meals to patients at Kirby Hospital

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 12/01/73

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary Adminastar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: N/A Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/99 Ending: 11/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	297,168	26,038	16,041	339,247	1,663	340,910	(81,110)	259,800			1
2	Food Purchase		193,160		193,160		193,160	(41,729)	151,431			2
3	Housekeeping	84,102	18,081	142	102,325	6	102,331		102,331			3
4	Laundry	24,555	16,419	51,240	92,214		92,214		92,214			4
5	Heat and Other Utilities			83,232	83,232		83,232		83,232			5
6	Maintenance	113,581	31,480	30,452	175,513	753	176,266		176,266			6
7	Other (specify):* Mat'l Management	6,774	1,208		7,982		7,982	(32)	7,950			7
8	**TOTAL General Services**	526,180	286,386	181,107	993,673	2,422	996,095	(122,871)	873,224			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	1,446,880	141,783	208,258	1,796,921	8,506	1,805,427		1,805,427			10
10a	Therapy	17,152	168	15,204	32,524		32,524		32,524			10a
11	Activities	86,119	2,845	1,247	90,211	351	90,562		90,562			11
12	Social Services	35,802	821	3,588	40,211	1,186	41,397		41,397			12
13	Nurse Aide Training	(42)	50	140	148		148	(1,019)	(871)			13
14	Program Transportation			2,637	2,637	(1,480)	1,157		1,157			14
15	Other (specify):* Volunteers	14,194	736	157	15,087	46	15,133	(402)	14,731			15
16	**TOTAL Health Care and Programs**	1,600,105	146,403	232,431	1,978,939	8,609	1,987,548	(1,421)	1,986,127			16
	C. General Administration											
17	Administrative	56,489			56,489		56,489		56,489			17
18	Directors Fees							3,448	3,448			18
19	Professional Services			5,450	5,450		5,450		5,450			19
20	Dues, Fees, Subscriptions & Promotions			18,749	18,749		18,749	(1,161)	17,588			20
21	Clerical & General Office Expenses	144,928	15,366	58,968	219,262	(12,583)	206,679	(23,700)	182,979			21
22	Employee Benefits & Payroll Taxes			558,752	558,752		558,752	(3,121)	555,631			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,727	6,727		6,727		6,727			24
25	Other Admin. Staff Transportation			998	998		998		998			25
26	Insurance-Prop.Liab.Malpractice			11,863	11,863		11,863	(462)	11,401			26
27	Other (specify):*											27
28	**TOTAL General Administration**	201,417	15,366	661,507	878,290	(12,583)	865,707	(24,996)	840,711			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,327,702	448,155	1,075,045	3,850,902	(1,552)	3,849,350	(149,288)	3,700,062			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Piatt County Nursing Home #0020255 Report Period Beginning: 12/01/99 Ending: 11/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			186,647	186,647		186,647		186,647			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(10,373)	(10,373)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			3,480	3,480		3,480		3,480			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			190,127	190,127		190,127	(10,373)	179,754			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					1,480	1,480		1,480			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops		30		30		30		30			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,850	54,850		54,850		54,850			42
43	Other (specify):* PCSS,FIA,Baer	46,448	14,327	16,988	77,763	72	77,835	(77,835)				43
44	**TOTAL Special Cost Centers**	46,448	14,357	71,838	132,643	1,552	134,195	(77,835)	56,360			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,374,150	462,512	1,337,010	4,173,672		4,173,672	(237,496)	3,936,176			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/99 Ending: 11/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients	(1,095)	2		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(118,689)	1&2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(32)	7		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(10,373)	32		10
11	Discounts, Allowances, Rebates & Refunds	(308)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,161)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Misc,PCSS,FIA,Baer	(109,892)	Misc		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (241,550)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	4,054	Var	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 4,054		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (237,496)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	X		$ 1,480	14	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 1,480		47

STATE OF ILLINOIS **Page 5A**

Piatt County Nursing Home

ID# 0020255

Report Period Beginning: 12/01/99

Ending: 11/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Patient Meals	$ (118,689)	1	1
2	Diet Supplies - Kirby	(2,747)	1	2
3	Volunteers - Courtesy Cart	(402)	15	3
4	N.A. Training Expense Recovery	(1,019)	13	4
5	Vending Machine Income	(3,121)	22	5
6	Operating Income - Foundation Reimbursement	(24,286)	21	6
7	Jury Duty Recovery	(20)	21	7
8	Insurance Recovery	(462)	26	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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85				85
86				86
87				87
88				88
89				89
90	**Total**	(150,746)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/99 Ending: 11/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(121,436)	0	0	0	0	0	0	0	0	0	0	(121,436)	1
2	Food Purchase	(1,403)	0	0	0	0	0	0	0	0	0	0	(1,403)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	(32)	0	0	0	0	0	0	0	0	0	0	(32)	7
8	**TOTAL General Services**	(122,871)	0	0	0	0	0	0	0	0	0	0	(122,871)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	(1,019)	0	0	0	0	0	0	0	0	0	0	(1,019)	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(402)	0	0	0	0	0	0	0	0	0	0	(402)	15
16	**TOTAL Health Care and Programs**	(1,421)	0	0	0	0	0	0	0	0	0	0	(1,421)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	3,448	0	0	0	0	0	0	0	0	0	3,448	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,161)	0	0	0	0	0	0	0	0	0	0	(1,161)	20
21	Clerical & General Office Expenses	(24,306)	287	0	0	0	0	0	0	0	0	0	(24,019)	21
22	Employee Benefits & Payroll Taxes	(3,121)	0	0	0	0	0	0	0	0	0	0	(3,121)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(462)	0	0	0	0	0	0	0	0	0	0	(462)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(29,050)	3,735	0	0	0	0	0	0	0	0	0	(25,315)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(153,342)	3,735	0	0	0	0	0	0	0	0	0	(149,607)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Piatt County Nursing Home** **# 0020255** **Report Period Beginning:** **12/01/99** **Ending:** **11/30/00**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,373)	0	0	0	0	0	0	0	0	0	0	(10,373)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(10,373)	0	0	0	0	0	0	0	0	0	0	(10,373)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(163,715)	3,735	0	0	0	0	0	0	0	0	0	(159,980)	45

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/99 Ending: 11/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		18	Nursing Home Comm Mtg	$		100.00%	$ 3,448	$ 3,448	1
2	V		21	IMRF/FICA		County Clerk Office	100.00%	287	287	2
3	V			Health Ins. Plan Reports						3
4	V			Fed & IL Income Tax						4
5	V			Unemployment Comp Report						5
6	V		21	Reconciling Bank Statement						6
7	V			Recording Checks; A/P & P/R		County Treasurer Office	100.00%	319	319	7
8	V			Check Signing; Funded Depr						8
9	V									9
10	V									10
11	V									11
12	V		22	IMRF/FICA	305,076		100.00%	305,076		12
13	V		22	SUTA & Health Insurance	195,577		100.00%	195,577		13
14	Total				$ 500,653			$ 504,707	$ * 4,054	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/99 Ending: 11/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/99 Ending: 11/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		N/A				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/99 Ending: 11/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	n/a						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Piatt County Nursing Home **#** 0020255 **Report Period Beginning:** 12/01/99 **Ending:** 11/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997		10
1998		11
1999		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/99 Ending: 11/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,120 B. General Construction Type: Exterior Brick Frame Comb w/ Sprinkler Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility Site	182,952	1973	$ 35,000	1
2					2
3	TOTALS	182,952		$ 35,000	3

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1973	1970	$ 800,000	$ 26,667	30	$ 26,667	$	$ 720,009	4
5	36		1975	1974	525,102	17,504	30	17,504		453,573	5
6	4		1989	1989	863,408	28,780	30	28,780		330,970	6
7	Bldg Proj		1993	1992	244,299	8,144	30	8,144		61,074	7
8											8
	Improvement Type**										
9	Building Improvements			1976	7,130		20			7,130	9
10	Building Improvements			1977	8,236		20			8,236	10
11	Building Improvements			1978	541		20			541	11
12	Building Improvements			1979	4,254		5			4,254	12
13	Building Improvements			1980	170,832	4,266	20	4,266		170,832	13
14	Building Improvements			1981	6,276	314	20	314		6,122	14
15	Building Improvements			1982	6,960	348	20	348		6,438	15
16	Building Improvements			1983	56,871	2,844	20	2,844		49,768	16
17	Building Improvements			1984	1,490		5			1,490	17
18	Building Improvements			1984	1,831		10			1,831	18
19	Building Improvements			1984	7,260	363	20	363		5,990	19
20	Building Improvements			1985	962		5			962	20
21	Building Improvements			1985	18,315	916	20	916		14,198	21
22	Building Improvements			1986	6,415		10			6,415	22
23	Building Improvements			1986	5,472	274	20	274		3,973	23
24	Building Improvements			1987	7,987		5			7,987	24
25	Building Improvements			1987	3,597		10			3,597	25
26	Building Improvements			1987	1,000	67	15	67		904	26
27	Building Improvements			1987	1,509	75	20	75		1,013	27
28	Building Improvements			1988	5,395		5			5,395	28
29	Building Improvements			1988	22,150	1,477	15	1,477		18,462	29
30	Building Improvements			1988	22,737	1,137	20	1,137		14,212	30
31	Building Improvements			1989	72,494	4,833	15	4,833		55,579	31
32	Building Improvements			1989	18,169		5			18,169	32
33	Building Improvements			1990	13,836	922	15	922		9,681	33
34	Building Improvements			1991	1,120		5			1,120	34
35	Building Improvements			1991	2,890	289	10	289		2,746	35
36	TOTAL (lines 4 thru 35)				$ 2,908,538	$ 99,220		$ 99,220	$	$ 1,992,671	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1991	44,194	2,946	15	2,946		27,987	9
10	Building Improvements			1992	5,532	553	10	553		4,701	10
11	Building Improvements			1993	21,036	2,104	10	2,104		15,780	11
12	Building Improvements			1994	5,888	589	10	589		3,828	12
13	Building Improvements			1995	8,381	838	10	838		4,609	13
14	Building Improvements: Remodeled ADM office, Remodel Halcyon			1996	7,582	758	10	758		3,411	14
15	Room; Replace crash rails in 50's & 60's Halls										15
16	Building Improvements: New pipes & New Roof			1997	227,748	11,388	20	11,388		39,857	16
17	Building Improvements: New water heater			1998	5,377	358	15	358		895	17
18	Building Improvements: Painting Room & Halls; Water Heater Install			1998	4,046	202	20	202		505	18
19	Building Improvements: Security System; Heat Pumps			1999	17,009	3,402	5	3,402		5,103	19
20	Building Improvements:Kitchen remodeling;Halcyon Roof & Remodel			1999	85,221	4,261	20	4,261		6,392	20
21	Bldg Improve: Telephones & Wiring; Handicap Door; Carrier Units			2000	13,585	1,359	10	1,359		1,359	21
22	Bldg Improve: Patient overbed lighting; Dining Room Remodel			2000	23,373	1,558	15	1,558		1,558	22
23	Grounds Improvement			1976	954					954	23
24	Grounds Improvement			1977	2,298					2,298	24
25	Grounds Improvement			1978	1,729		10			1,729	25
26	Grounds Improvement			1979	6,235		10			6,235	26
27	Grounds Improvement			1980	3,031		10			3,031	27
28	Grounds Improvement			1981	2,803		10			2,803	28
29	Grounds Improvement			1982	1,196		10			1,196	29
30	Grounds Improvement			1983	1,212		12			1,212	30
31	Grounds Improvement			1984	7,796		10			7,796	31
32	Grounds Improvement			1986	1,077		10			1,077	32
33	Grounds Improvement			1987	6,713		3			6,713	33
34	Grounds Improvement			1987	1,118		10			1,118	34
35	Grounds Improvement			1989	11,701		10			11,701	35
36	TOTAL (lines 4 thru 35)				$ 516,835	$ 30,316		$ 30,316	$	$ 163,848	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Grounds Improvement			1990	2,682	136	10	136		2,682	9
10	Grounds Improvement			1992	51,409	5,141	10	5,141		43,698	10
11	Grounds Improvement			1993	4,988	499	10	499		3,742	11
12	Grounds Improve: News signs @ front/rear entrance;re-stripe pkg lot			1996	9,884	988	10	988		4,446	12
13	Grounds Improve: Tree removal & excavation			1998	8,691						13
14	Grounds Improve: Halcyon Awning; truck turnaround; sidewalk rails			1998	6,461	646	10	646		1,615	14
15	Grounds Improve: Tile repair			1999	765	77	10	77		115	15
16	Grounds Improve: Concrete Patio			2000	2,107	211	10	211		211	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 86,987	$ 7,698		$ 7,698	$	$ 56,509	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 242,069	$ 38,468	$ 38,468	$		$ 159,673	37
38	Current Year Purchases	57,923	6,728	6,728			6,728	38
39	Fully Depreciated Assets	345,678	4,219	4,219			345,678	39
40								40
41	TOTALS	$ 645,670	$ 49,415	$ 49,415	$		$ 512,079	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Van-transportation	Dodge 1987	1987	$ 22,745	$	$	$	5	$ 22,745	42
43	Wheelchair Lift	Braun L400 1996	1996	3,495	350	350		10	1,575	43
44										44
45										45
46	TOTALS			$ 26,240	$ 350	$ 350	$		$ 24,320	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 4,219,270	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 186,999	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 186,999	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,749,427	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	N/A	$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58	N/A	$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1975	Storage Rent		$ 3,480	N/A	N/A	3
4	Additions							4
5								5
6								6
7	TOTAL				$ 3,480 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☒ X NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/99 Ending: 11/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		140		140
8	Nurse Aide Competency Tests		50		50
9	TOTALS	$	$ 190	$	$ 190
10	SUM OF line 9, col. 1 and 2 (e)	$ 190			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,3	hrs	$	522	$	8,148	$	522	$ 8,148	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		41		1,700		41	1,700	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10a,1 & 3	1006 hrs	17,152	350		5,356		1,356	22,508	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	10,2	# of prescrpts					15,280		15,280	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			$ 17,152	913	$	15,204	$ 15,280	1,919	$ 47,636	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Piatt County Nursing Home # 0020255 **Report Period Beginning:** 12/01/99 **Ending:** 11/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 99,722	$ 410,027	1
2	Cash-Patient Deposits		5,044	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	326,524	394,319	3
4	Supply Inventory (priced at LCM)	59,236	59,236	4
5	Short-Term Investments			5
6	Prepaid Insurance	5,901	5,901	6
7	Other Prepaid Expenses	6,263	6,263	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 497,646	$ 880,790	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	35,000	35,000	13
14	Buildings, at Historical Cost	3,624,168	3,624,168	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	645,670	645,670	16
17	Accumulated Depreciation (book methods)	(2,725,105)	(2,725,105)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Monticello Grain Stock	133	133	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,579,866	$ 1,579,866	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,077,512	$ 2,460,656	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 107,928	$ 107,928	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		5,044	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	35,790	35,790	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Employee Benefits	224,632	224,632	36
37	Interfund Payable	68,830	68,830	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 437,180	$ 442,224	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 437,180	$ 442,224	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,640,332	$ 2,018,432	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,077,512	$ 2,460,656	48

***(See instructions.)**

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/99 Ending: 11/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,721,729	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,721,729	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(81,397)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (81,397)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,640,332	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/99 Ending: 11/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,469,705	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,469,705	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	1,095	5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,095	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	1,019	11
12	Gift and Coffee Shop	402	12
13	Barber and Beauty Care	3,136	13
14	Non-Patient Meals	65,369	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	2,779	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 72,705	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10,373	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10,373	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule	630,523	28
28a	Interfund Transfers	(92,126)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 538,397	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,092,275	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	993,673	31
32	Health Care	1,978,939	32
33	General Administration	878,290	33
	B. Capital Expense		
34	Ownership	190,127	34
	C. Ancillary Expense		
35	Special Cost Centers	132,643	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,173,672	40
41	**Income before Income Taxes (line 30 minus line 40)****	(81,397)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (81,397)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/99 Ending: 11/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,376	1,711	$ 37,597	$ 21.97	1
2	Assistant Director of Nursing	1,724	2,102	39,547	18.81	2
3	Registered Nurses	16,912	19,330	334,976	17.33	3
4	Licensed Practical Nurses	11,811	13,581	193,468	14.25	4
5	Nurse Aides & Orderlies	78,826	87,106	817,575	9.39	5
6	Nurse Aide Trainees		(5)	(42)	8.40	6
7	Licensed Therapist	818	1,006	17,152	17.05	7
8	Rehab/Therapy Aides					8
9	Activity Director	315	315	4,309	13.68	9
10	Activity Assistants	8,288	9,404	81,810	8.70	10
11	Social Service Workers	2,618	2,862	35,661	12.46	11
12	Dietician					12
13	Food Service Supervisor	1,952	2,472	38,600	15.61	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,562	34,319	258,568	7.53	15
16	Dishwashers					16
17	Maintenance Workers	9,753	10,907	120,356	11.03	17
18	Housekeepers	9,676	11,046	84,102	7.61	18
19	Laundry	3,219	3,510	24,555	7.00	19
20	Administrator	2,075	2,342	56,489	24.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,808	11,232	144,928	12.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) NSS,VOL,PCSS,F	7,712	8,827	84,499	9.57	33
34	TOTAL (lines 1 - 33)	198,445	222,067	$ 2,374,150 *	$ 10.69	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	659	$		50
51	Licensed Practical Nurses	4,784			51
52	Nurse Aides	2,227			52
53	TOTAL (lines 50 - 52)	7,670	$ 191,095		53

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/99 Ending: 11/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marilyn Benedino	Administrator		$ 33,568
Karla Bradley	Executive Dir.		22,921
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 56,489

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
May, Cocagne, & King, P.C.	Audit	$ 5,450
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 5,450

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 36,000
Unemployment Compensation Insurance	20,884
FICA Taxes	191,932
Employee Health Insurance	175,806
Employee Meals	7,757
Illinois Municipal Retirement Fund (IMRF)*	122,678
Employee Awards Program & Assist Program	3,695
Less: Vending Income	(3,121)
TOTAL (agree to Schedule V, line 22, col.8)	$ 555,631

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	9,658
Health Care Worker Background Check	
(Indicate # of checks performed 8)	96
Joint Commission Dues	1,881
LSN Dues	4,164
ASA	135
IL Rural Health	250
Subscriptions	1,069
Employers Association	335
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,588

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,104
Seminar Expense	5,623
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,727

**See instructions.

Facility Name & ID Number Piatt County Nursing Home # 0020255 Report Period Beginning: 12/01/99 Ending: 11/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Piatt County Nursing Home # 0020255 **Report Period Beginning:** 12/01/99 **Ending:** 11/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **JCAH $1881, LSN $4164, ASA $135**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5,10,15,20**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **39,941** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **54,900**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **15,975**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **May, Cocagne, & King, P.C.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

PIATT COUNTY NURSING HOME
COST CENTER EXPENSES
SUPPORTING SCHEDULE

SCHEDULE V, LINE 7 - GENERAL SERVICES:

MATERIALS MANAGEMENT:

SALARIES	$6,774
CS INVENTORY SUPPLIES - KIRBY	32
OTHER SUPPLIES	1176
	$7,982

SCHEDULE V, LINE 15 - HEALTH CARE & PROGRAMS

VOLUNTEER PROGRAM COORDINATOR:

SALARIES & WAGES	$14,194
COURTESY CART SUPPLIES	364
OTHER SUPPLIES	372
STAFF DEVELOPMENT	125
TRAVEL	32
	$15,087

SCHEDULE V, LINE 43 - SPECIAL COST CENTERS:

PIATT COUNTY SERVICES FOR SENIORS:

SALARIES & WAGES	$29,625
TELEPHONE EXPENSE	1004
POSTAGE EXPENSE	264
COPIER EXPENSE	326
SUPPLIES	552
INSURANCE	239
SECRETARIAL SERVICE	3600
RENTAL EXPENSE	1200
STAFF DEVELOPMENT	30
TRAVEL	3762
	$40,602

Piatt County Nursing Home serves as the Grant Sponsor for this agency which is chiefly supported by an Area Agency Grant. All expenses for this agency have been eliminated on Schedule V, Line 43.

FAITH IN ACTION:

SALARIES & WAGES	$16,823
TELEPHONE EXPENSE	1131
POSTAGE EXPENSE	462
COPIER EXPENSE	243
SUPPLIES	457
PAMPHLETS	448
VOLUNTEER RECOGNITION	524
INSURANCE	510
RENTAL EXPENSE	720
FUNDRAISING EXPENSE	11051
STAFF DEVELOPMENT	866
DUES & FEES	410
TRAVEL	444
	$34,089

Piatt County Nursing Home serves as the Grant Sponsor for this agency which is chiefly supported by a Robert Wood Johnson grant. All expenses for this agency have been eliminated on Schedule V, Line 43.

PIATT COUNTY NURSING HOME
COST CENTER EXPENSES
SUPPORTING SCHEDULE

BAER PROPERTY:

PROPERTY TAXES	$2,245
INSURANCE	462
SERVICE ON DEMAND	365
	$3,072

This property expense is incurred on Piatt County Foundation property. All expenses have been eliminated from Schedule V, Line 43.

PIATT COUNTY NURSING HOME
SUPPORTING SCHEDULE
SCHEDULE XVII - INCOME STATEMENT
LINE 28 - OTHER REVENUE

November 30, 2000

VENDING MACHINE INCOME	$3,121
JURY DUTY RECOVERY	20
DEPARTMENT HEAD CONSULTING SERVICES	180
N.A. TRAINING CONTRACTUAL RECOVERY	120
INSURANCE/DAMAGE RECOVERY	462
PURCHASE REBATES	308
WRITE-OFF ACCOUNTS RECEIVABLE	(3282)
MISCELLANEOUS DONATIONS	1222
GAIN/LOSS ON SALE OF ASSETS	(1002)
FOUNDATION CONTRIBUTION	24286
PIATT COUNTY SERVICES FOR SENIORS INCOME	34169
FAITH IN ACTION INCOME	24127
TRANSFERS FROM COUNTY	543792
BAER PROPERTY REVENUE	3000
	$630,523

SCHEDULE XVIIA

FACILITY NAME: PIATT COUNTY NURSING HOME ID#: 0020255

Cost Report Period: 12/01/99 through 11/30/00

This supplement to the cost report Schedule XVII must be filed by all government-owned long term care facilities. This schedule will provide details regarding revenue reported as "Other Government Grants" on line 10 of Schedule XVII.

Federal Grants: Amount

Agency N/A Date Received ____/____/____ $ _____

Description _____

_____

Agency N/A Date Received ____/____/____ $ _____

Description _____

_____

State Grants:

Agency N/A Date Received ____/____/____ $ _____

Description _____

_____

Agency N/A Date Received ____/____/____ $ _____

Description _____

_____

Other Grants:

Agency N/A Date Received ____/____/____ $ _____

Description _____

_____

Agency N/A Date Received ____/____/____ $ _____

Description _____

_____

TOTAL GRANTS RECEIVED $0

PIATT COUNTY NURSING HOME
SUPPORT SCHEDULES
November 30, 2000

Schedule XIX, Section G - Schedule of Travel & Seminar

Seminar Expense - Staff Development
Administration

J. Redman, Administrative Assistant
Powerpoint Level I Software Training; Willis Computing
Champaign, IL 4/4-6/00 197

M. Benedino, Administrator
AAHSA Spring Conference & Exposition
Washington, D.C. 3/10-13/00 1204

M. Benedino, Administrator
Powerpoint Level I Software Training; Willis Computing
Champaign, IL 4/4-6/00 197

M. Benedino, Administrator
LSN 2000 Annual Convention - Explore New Perspectives
Chicago, IL 4/10-12/00 555

K. Bradley, Executive Director
Review Course for IL Licensure Exam; IL Healthcare Association
Springfield, IL 5/31-6/1/00 652

K. Bradley, Executive Director
"Pioneer Approaches"; Illinois Department on Aging
Springfield, IL 09/13/00 49

K. Bradley, Executive Director
State Boards; LNHA
Springfield, IL 10/12/00 240

K. Bradley, Executive Director
Federal Boards; LNHA
Springfield, IL 10/30/00 433

K. Bradley, Executive Director
Wellspring Staff Model Seminar; Apostolic Christian Homes
Green Bay, WI 11/19-20/00 133

S. Gadbury, Personnel Coordinator
The Essentials of Payroll Management; National Seminars Group
Champaign, IL 04/27/00 200

S. Gadbury, Personnel Coordinator
"H" in Healthy Stands for Humor; Provena Medical Center
Urbana, IL 09/13/00 14

S. Craig, Personnel Director
Access I Software Training; Willis Computing
Champaign, IL 1/18 & 20/00 165

PIATT COUNTY NURSING HOME
SUPPORT SCHEDULES
November 30, 2000

Schedule XIX, Section G - Schedule of Travel & Seminar (continued)

S. Craig, Personnel Director
LSN 2000 Annual Convention - Explore New Perspectives
Chicago, IL 4/10-12/00 555

S. Craig, Personnel Director
Central IL Counselor/Coordinator Annual SHIP Conference
Springfield, IL 10/23/00 39

S. Craig, Personnel Director
Wellspring Staff Model Seminar; Apostolic Christian Homes
Green Bay, WI 11/19-20/00 133

K. Glennon, Accounting Coordinator
Access I Software Training; Willis Computing
Champaign, IL 1/18 & 20/00 190

K. Glennon, Accounting Coordinator
Medicare PPS, Coinsurance, Billing, and Medicaid; Life Services Network
Springfield, IL 02/01/00 135

K. Glennon, Accounting Coordinator
Access II Software Training; Willis Computing
Champaign, IL 4/12-14/00 299

K. Glennon, Accounting Coordinator
Benchmarking User Group Meeting; Life Services Network
Schaumburg, IL 05/31/00 233